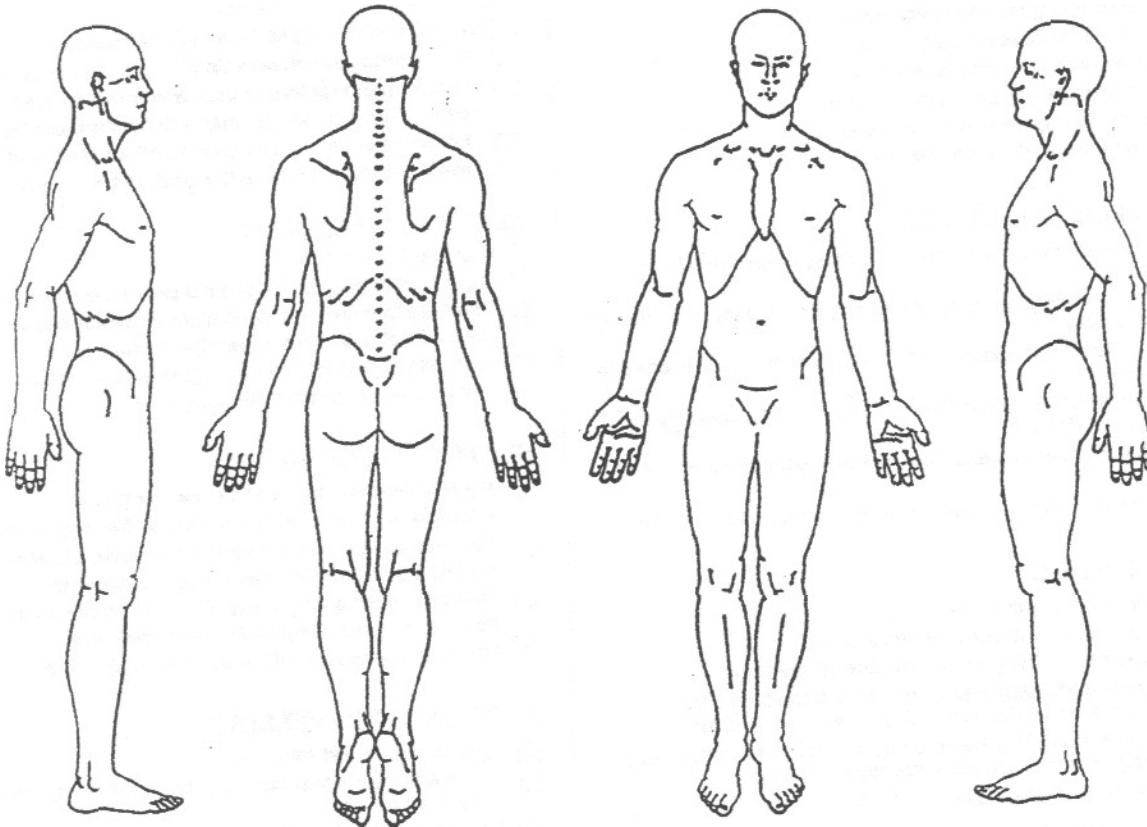


## Daily Patient Record

Name \_\_\_\_\_

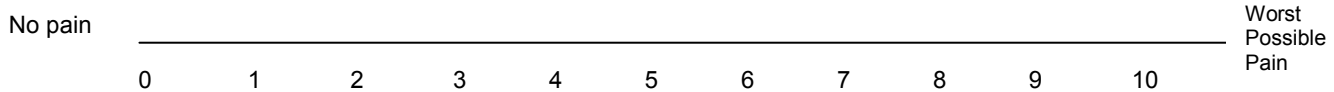
Date \_\_\_/\_\_\_/\_\_\_

Please use an X to accurately mark the area in which you feel pain and other symptoms. **Include ALL affected areas.**

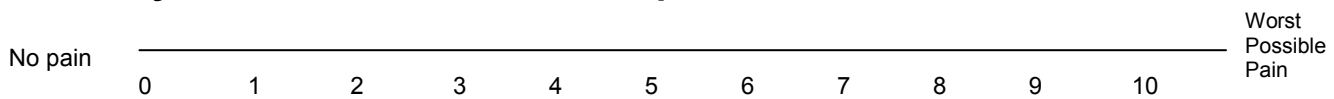


Please circle the number that best describes the questions below.

### What is your pain RIGHT NOW?



### What is your TYPICAL or AVERAGE pain?



Patient Signature \_\_\_\_\_